



National Transportation Safety Board

FY21 USDA/APHIS/Wildlife Services Aviation Safety Meeting

Robert L. Sumwalt

December 15, 2020

**Lessons from the Ashes:
How good pilots end up in bad situations.**



An Impressive Operation



An Impressive Operation

- Full time crew
- Impeccable maintenance
- High training standards
- Going above minimum standards
- Positive audit comments

Positive Audit Comments

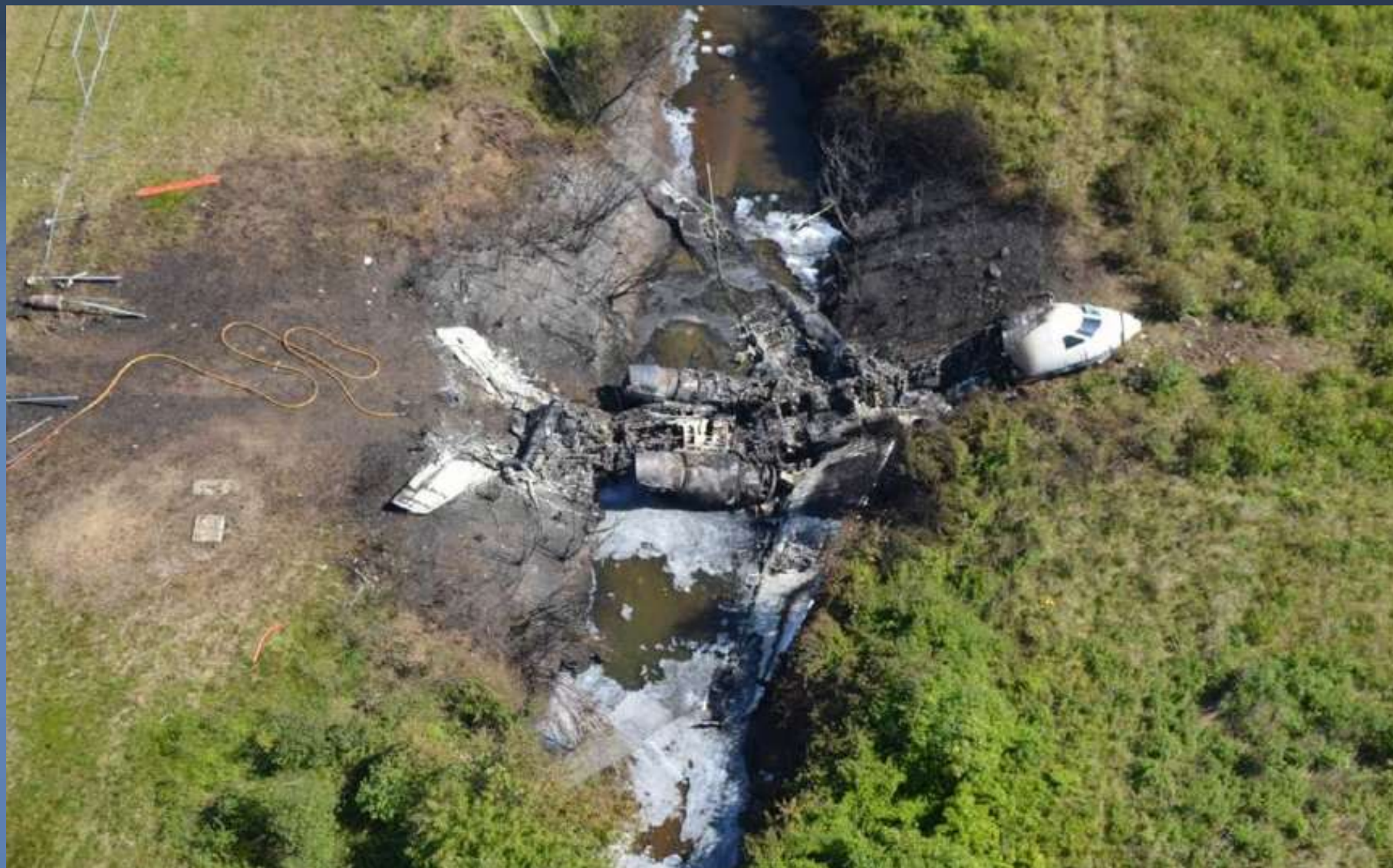
- “The SMS of this operator is well-developed”
- “Best practices are consistently employed in all facets of the program”
- “Continuous SMS improvement is actively pursued”
- “The Flight Ops Manual is remarkably well-written and comprehensive”
- “Safety culture within the department is shared among all team members”
- “Open reporting of hazards is consistently encouraged by management”
- “Solid safety program, maturing nicely”

Gulfstream G-IV Crash

Bedford, MA

May 31, 2014

7 Fatalities





NTSB Investigation Found

- The flight crew failed to disengage the gust lock.
- None of the five manufacturer specified-checklists were verbalized on the accident flight.
- No complete flight control check for 173 of the past 175 flights.

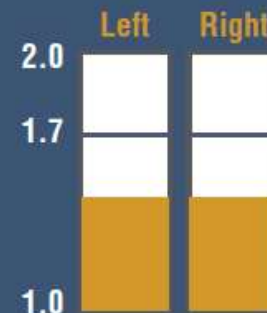




2139:59 **PIC** (steer) lock is on.
 2140:02 **PIC** (steer) lock is on.
 2140:03 **PIC** (steer) lock is on.
 2140:04 **PIC** (steer) lock is on.
 2140:06 **PIC** (steer) lock is on.
 2140:07 **PIC** (steer) lock is on.

Rwy 11-29 at BED Hanscom Field is 7001 x 150 ft plus there is another 1000 ft of paved overrun before the abrupt encounter with the raised bank of the Shawsheen River.

Engine pressure ratio (EPR)



AUTOTHROTTLE

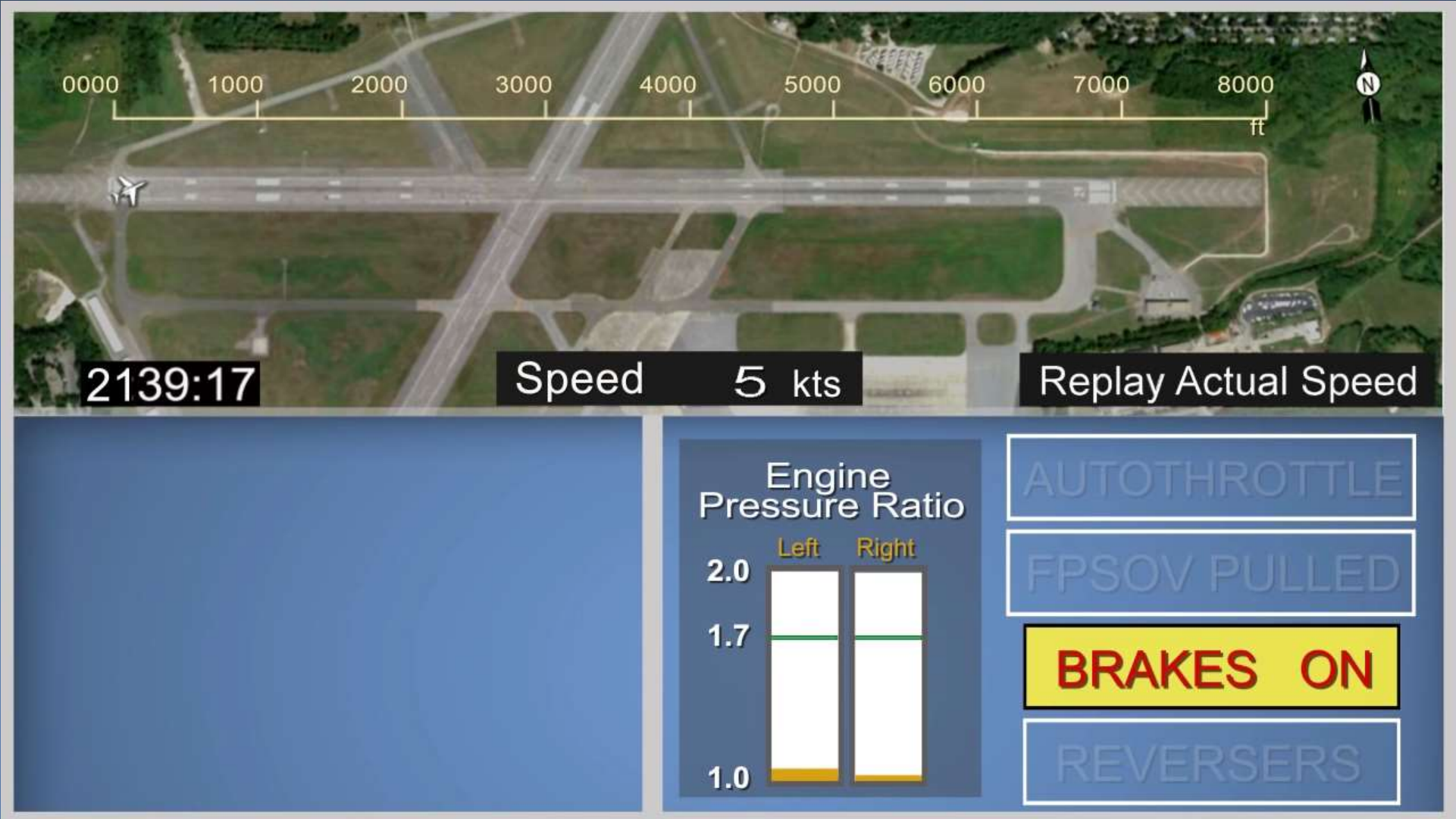
FPSOV PULLED

BRAKES ON

REVERSERS



NTSB



The big question:

**WHY WOULD AN EXPERIENCED
FLIGHT CREW PERFORM THIS WAY?**

Procedural Drift

- “When flight crewmembers perform a routine check repeatedly over a long period of time and never encounter an example of its effectiveness as a safety protection, they may experience a decreased perception of the check’s importance.”
- “As a result, they may begin to skip the check and reallocate their efforts toward other goals that they regard as more important.”

Procedural Drift

- “Such changes can lead to the development of new group norms about what is expected and an increasing mismatch between written guidance and actual operating practice.”
- “This increasing mismatch has been described as ‘procedural drift’.”

com·pla·cen·cy

/kəm'plāsənsē/ 

noun

a feeling of smug or uncritical satisfaction with oneself or one's achievements.

"the figures are better, but there are no grounds for complacency"

synonyms: smugness, self-satisfaction, self-congratulation, self-regard; gloating, triumph, pride; satisfaction, contentment

"the complacency he felt as a math student was abruptly shaken when he took his first calculus exam"



A fine line

- “There is a fine line separating a relaxed and easy atmosphere in a cockpit from a lax one where distractions can result in critical failures.”
- “Professionalism may be described as knowing the difference between the two.”
 - Honorable John K. Lauber

NTSB Response Operations Center





Could this be you?

**“The best way to predict the
future is to create it.”**

- Peter Drucker

Creating a Future of Safety: Two Questions

1. What is our level of Professionalism, Standardization, and Procedural Compliance?
2. How strong is our Safety Culture?

Creating a Future of Safety

PROFESSIONALISM, STANDARDIZATION, AND PROCEDURAL COMPLIANCE



What is the attitude around here?

What is a professional?

- A mindset
 - Precise checklist usage
 - Precise compliance with SOPs and regulations
 - Staying abreast and current with knowledge and skills
 - The ability and willingness to say “I don’t know” or “I am wrong”
 - The willingness to say “no.”

**Cessna 310, N501N
July 10, 2007
Sanford, FL
5 fatalities**





Declared Emergency

“Smoke in the cockpit.”

“Shutting off radios, elec.”



Pictures from Terry A. Boyd

Maintenance Discrepancy Entry

AIRCRAFT: N561N	DATE: 07-09-07	-ACTT	
		-ACTL	
MAINTENANCE WRITE-UP		MAINTENANCE CLEARING ACTION	
Entered By: ACT	Location: DAB	<input type="checkbox"/> Repaired	<input type="checkbox"/> Replaced
		<input type="checkbox"/> Released- Could Not Duplicate	<input type="checkbox"/> Loaner Installed
RADAR WENT BLANK DURING CRUISE FLIGHT. RECYCLED - NO RESPONSE... SMELL OF ELECTRICAL COMPONENTS BURNING TURNED OFF UNIT - PULLED RADAR C.B. - SMELL WENT AWAY. - RADAR INOP		Corrective Action:	

MECHANIC: “We have a discrepancy with the airplane.”

PILOT: “I know about the radar, I don’t give a # about that, I’m taking the airplane.”

As recounted by mechanic. Source: Ops Group Factual Report. p. 24

Organizations don't follow their SOPs

- Aviation director could not readily locate SOP manual
- SOP manual viewed as a “training tool”
- Aircraft to only be used for company business
 - Accident flight was a personal flight
- PIC must possess ATP
 - PIC did not possess ATP
- Last 3 maintenance discrepancies had not been addressed

Stated the NTSB:

- “This is contrary to industry guidance for SOPs indicating that procedures should be written the way the organization intends to operate, and once the procedures are in place, the organization makes every effort to operate that way.”

5 in 5



Pittsburgh, Sept 1994



USAir 1016
July 2, 1994
Charlotte, North Carolina
37 fatalities



Crash sharpens painful memories of 1994 tragedy

By **NICOLE SWEENEY**
and **JEFF STENSLAND**
Staff Writers

It's been nearly a decade since USAir Flight 1016 plummeted from stormy skies in Charlotte, but the pain is still fresh for Wayne Mattox of Winnsboro, whose brother was one of 37 to die in the crash.

Steve Mattox and his bride, Rita, vowed to spend the rest of their lives together that day, not knowing their lives would end just hours later.

News of Wednesday's airplane crash in Charlotte brought back a torrent of memories for the Mattox family and others.



NTSB

Failure to follow procedures led to crash, board finds

By CHARLES POPE
Washington Bureau

WASHINGTON — USAir Flight 1016 crashed last year after its pilots blundered into a severe thunderstorm shrouding the Charlotte airport and then responded incorrectly when the threat was recognized, federal safety officials concluded Tuesday.

The picture painted by the Na



Pilo

APRIL 5, 1995

NO. 95
104TH YEAR
4 SECTIONS
46 PAGES
© 1995 THE STATE

cited

n dangerous weather
near situation
asures to escape the wind shear

and complete weather

children
advisories

Failure to follow
procedures led
crash, board

NTSB



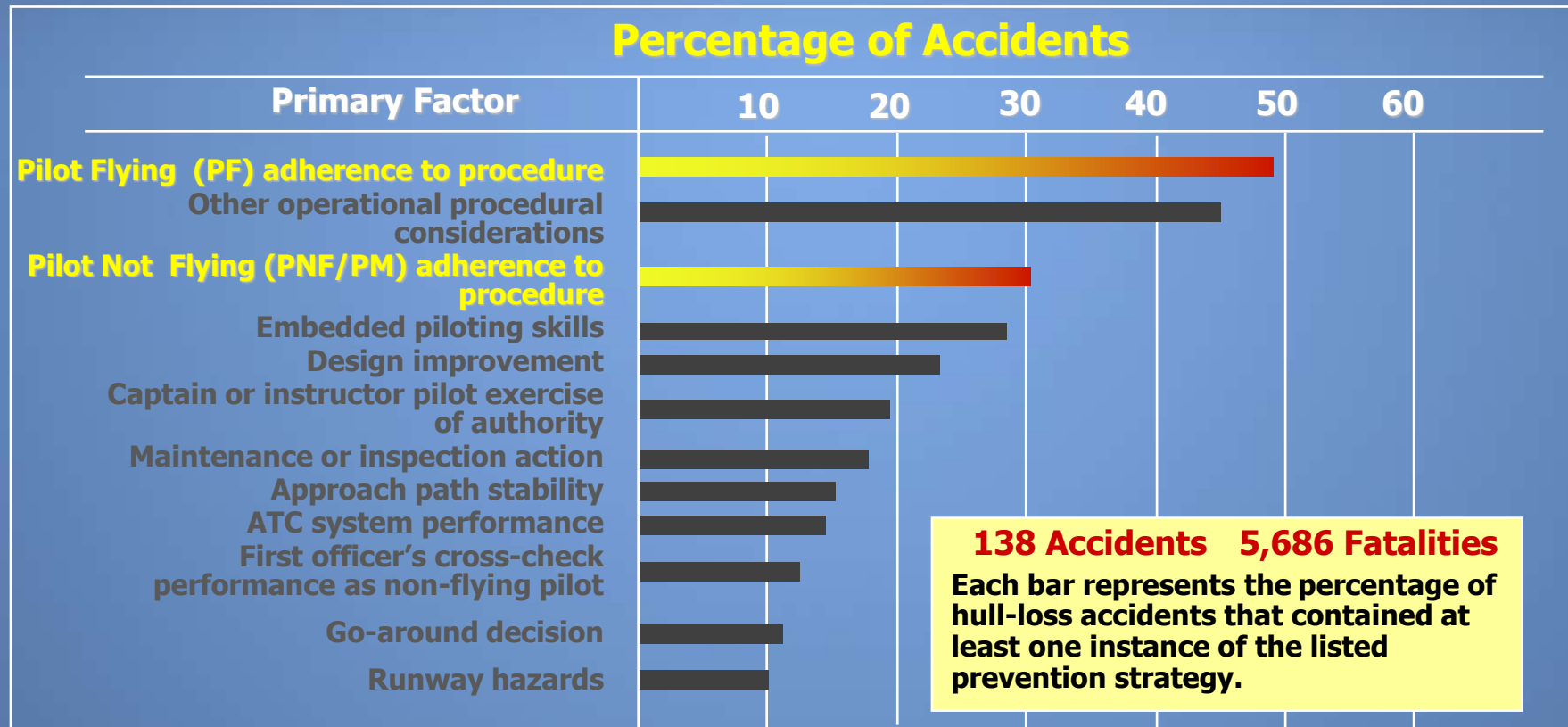
Lautman-Gallimore Study

- Found that having a strong commitment to standardization and discipline were among the “key elements of safe operations” observed in a Boeing study.
- “Cockpit procedural language is tightly controlled to maintain consistency and to avoid confusion from non-standard callouts Callouts and responses are done verbatim”

Accident Prevention Strategies

Source: Boeing study of accident prevention strategies

Hull-loss Accidents over 10 Year Period



Intentional non-compliance leads to other problems

- LOSA data revealed that, compared to crews who followed SOPs, crewmembers who intentionally deviated from procedures:
 - averaged making 3 times more errors
 - mismanaged more errors
 - found themselves in more undesired aircraft situations





1 COMPANY ORGANIZATION AND

1.1	SCANA AVIATION DEPARTMENT
1.2	AVIATION DEPARTMENT MANAGE
1.3	DUTIES, RESPONSIBILITIES, AND
1.4	COLLATERAL AND ADMINISTRATI
1.5	APPEARANCE, CONDUCT AND DI
1.6	GENERAL HEALTH AND INJURY P
1.7	PREGNANCY AND MATERNITY LE
1.8	USE OF ALCOHOL AND DRUGS...
1.9	SCANA DRUG TESTING PROGR
1.10	BLOOD DONATION AND SCUBA
1.11	EXPENSES REIMBURSEMENT
1.12	HOURS OF SERVICE, ON-CALL R
1.13	CONFIDENTIALITY OF CORPORAT
1.14	CHARTER AIRCRAFT OPERATION
1.15	AVIATION DEPARTMENT DOCUM
1.16	DEPARTMENT STAFF MEETINGS,
1.17	DEVELOPMENTAL OBJECTIVES F
1.18	SAFEGUARDING OF DEPARTMENT
1.19	DEPARTMENT PURCHASES AND F
1.20	AIRCRAFT INSURANCE

2 COMPANY SAFETY MANAGEM

2.1	SAFETY PHILOSOPHY
2.2	PURPOSE
2.3	RESPONSIBILITIES
2.4	COMPONENTS OF SCANA AVIAT
2.5	OPERATIONAL RISK MANAGEM

3 AIRCRAFT USE, SCHEDULING A

3.1	AIRCRAFT USE
3.2	AIRCRAFT SCHEDULING
3.3	OPERATIONAL CONTROL SYSTEM
3.4	RESPONSIBILITIES AND AUTHORI
3.5	RESPONSIBILITY AND AUTHORITY
3.6	FLIGHT PLANNING REQUIREMEN
3.7	PREFLIGHT ACTION
3.8	FLIGHT RULES TO BE FOLLOWED
3.9	FUEL REQUIREMENTS
3.10	FLIGHT FOLLOWING AND FLIGHT
3.11	AIRCRAFT WEIGHT AND BALANCE
3.12	RECORDING OF AIRCRAFT DEFEC
3.13	ENSURING AIRWORTHY AIRCRAF
3.14	NOTIFICATION OF UN-AIRWORTH
3.15	PIC AIRWORTHINESS DETERMIN
3.16	USE OF MINIMUM EQUIPMENT LI
3.17	DISTRIBUTION OF OPERATIONAL

4 OPERATING REQUIREMENTS....

4.1	GENERAL
4.2	OPERATIONAL PRIORITIES
4.3	MINIMUM AIRCRAFT CREW
4.4	FLIGHT AND DUTY TIME LIMITATI
4.5	HIGH MINIMUMS CAPTAIN

Table of Contents
Apr 30, 2006



PREAMBLE

This Flight Operations Manual provides policies and procedures for a performance of their duties. It is intended to provide current, authoritative respect to the planning, management and implementation of Aviation procedures contained in this manual are consistent with management

These policies and procedures have been developed to ensure the highest level of safety. Recognizing that all situations cannot be covered in this manual, it is expected at all times to exercise sound judgment in the performance of

Federal Aviation Regulations, aircraft and accessory manufacturers' policies and procedures also govern Aviation Department operations. by reference and will not necessarily be reproduced in this manual.

This manual is a living document and will be revised as needed. The actual operations of the Aviation Department.

A copy of this manual will be provided to each employee of the Aviation Department. Each employee will be responsible for maintaining the manual in the Record of Revisions each revision that is inserted.

This manual represents a consensual agreement between SCANA Management and the Aviation Department regarding the operations and maintenance of company aircraft and of

William B. Timmerman
Chief Executive Officer

Preamble
July 1, 2005



1 Company Organization and Administrative Information

1.1 SCANA Aviation Department Vision, Mission and Purpose

Business Description of SCANA Aviation Department

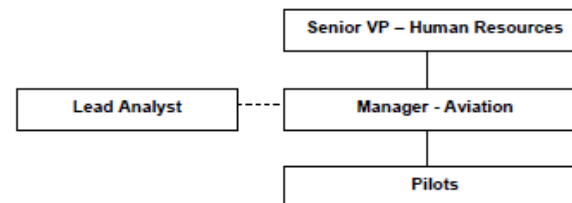
The SCANA Aviation Department provides safe, reliable, and cost-effective on-demand air transportation services for SCANA. SCANA offers this service as a business tool for the convenience, comfort and security of our people.

Strategic Direction of Department

The Aviation Department is focused on safety that is a result of operational excellence and professionalism – and on this we will not compromise. We strive to become a world-class aviation operation by identifying and exceeding industry best practices in safety, training, maintenance and procedures. We care deeply about the people we serve as we strive to become an indispensable part of the SCANA family.

1.2 Aviation Department Management Structure

The following is the organization structure of the SCANA Aviation Department:



1.3 Duties, Responsibilities, and Qualifications

1.3.1 Manager of Aviation

Reports to: Senior VP, Human Resources

Job Summary: Provides direction to assure Aviation Department performance achieves SCANA corporate goals and objectives associated with aviation safety, reliability, operational efficiency, productivity and customer satisfaction and monitors and administrates daily flight operations, maintenance and associated activities.

Duties and Responsibilities:

- Oversee and manage the SCANA Aviation Department, its personnel and aircraft;
- Ensure safety and security are the foremost goals of the Department;
- Serve as the primary interface between senior executive SCANA management and the Aviation Department;
- Ensure SCANA aircraft are safely, legally and properly scheduled, dispatched, operated and maintained, and that adequate records are kept to document compliance with these activities;
- Ensure SCANA Aviation personnel are properly trained and qualified and that adequate records are maintained to show compliance with these requirements;
- Develop and institute department policies and procedures that will accomplish the department's mission safely, effectively and efficiently.

Free Lesson

“Learn from the mistakes of others. You won’t live long enough to make them all yourself.”



Creating a Future of Safety: Two Questions

1. What is our level of Professionalism, Standardization, and Procedural Compliance?
2. How strong is our Safety Culture?

Creating a Future of Safety

SAFETY CULTURE



Zaleski, Ohio

January 2019

Direction of travel

“Survival Flight’s poor safety culture likely influenced the accident pilot’s decision to conduct the accident flight...”

Scattered airframe and medical interior debris

Main cabin

Engine and aft cabin

Cockpit instruments and cockpit floor

Tail boom

Tail rotor and tail boom

MR head and 3 MR blades

North

Near Santa Fe, NM

June 2009



“Contributing to the accident was an organizational culture that prioritized mission execution over aviation safety...”



NTSB

Safety Culture is:

“Safety culture is the core values and behaviors resulting from a collective commitment by leaders and individuals to emphasize safety over competing goals to ensure protection of people and the environment.”

Source: U.S. Nuclear Regulatory Commission

Safety Culture



Doing the right things, even when no one is watching.

Do you have a good safety culture?

Do you have a good safety culture?

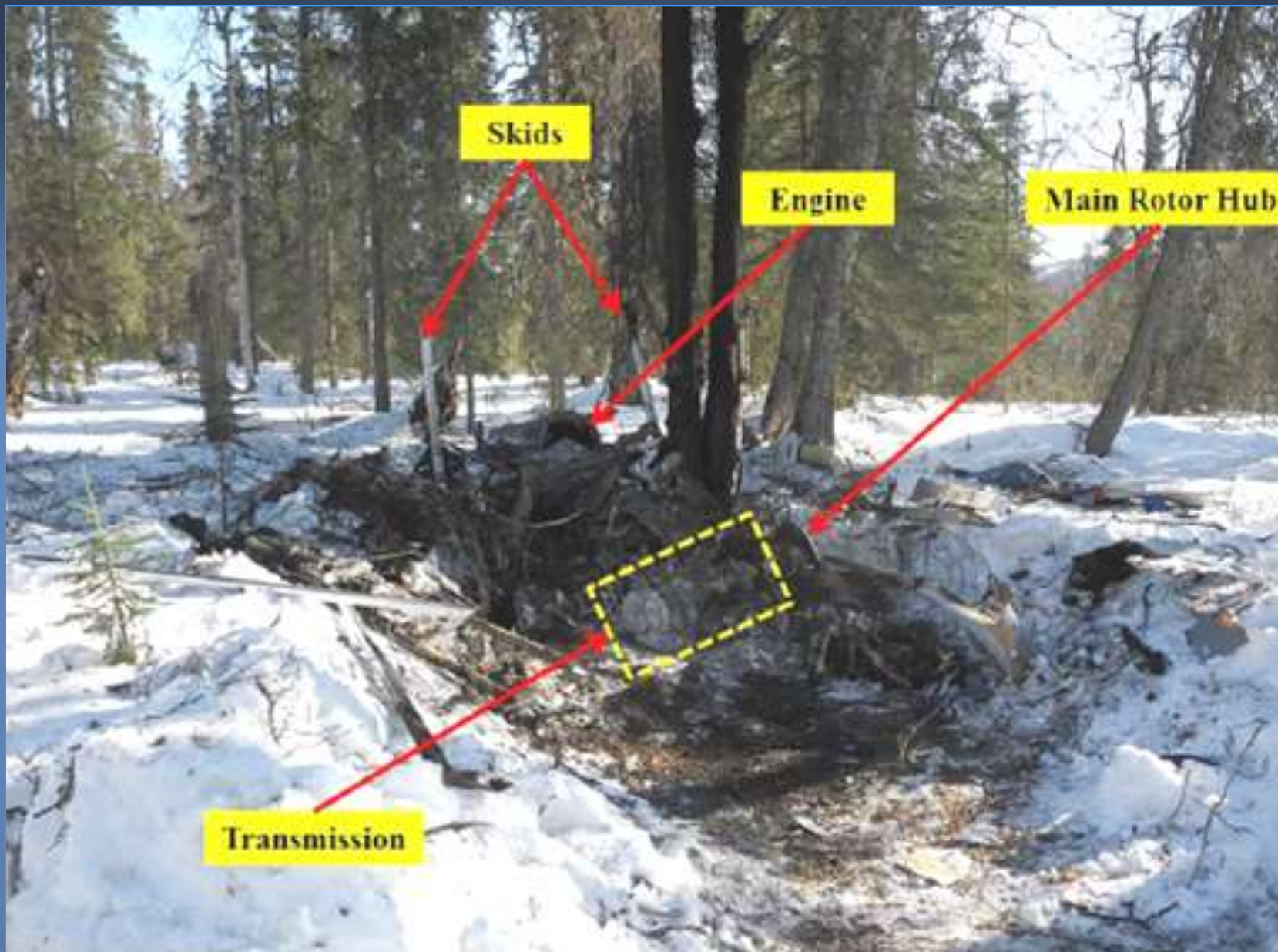
- “... it is worth pointing out that if you are convinced that your organization has a good safety culture, you are almost certainly mistaken.”
- “... a safety culture is something that is striven for but rarely attained...”
- “... the process is more important than the product.”

– James Reason, “Managing the Risks of Organizational Accidents.”

Alaska DPS



- March 30, 2013
- Eurocopter AS350
- SAR flight
- Talkeetna, Alaska
- 3 fatalities



NTSB Findings

- “The pilot’s exceptionally high motivation for search and rescue missions and past successes likely increased his risk tolerance and influenced his decision to continue flying in deteriorating weather conditions ...”
- “The Alaska Department of Public Safety lacked organizational policies and procedures to ensure that operational risk was appropriately managed, such as formal pilot weather minimums, preflight risk assessment forms ...”

Bedford, MA

May 2014

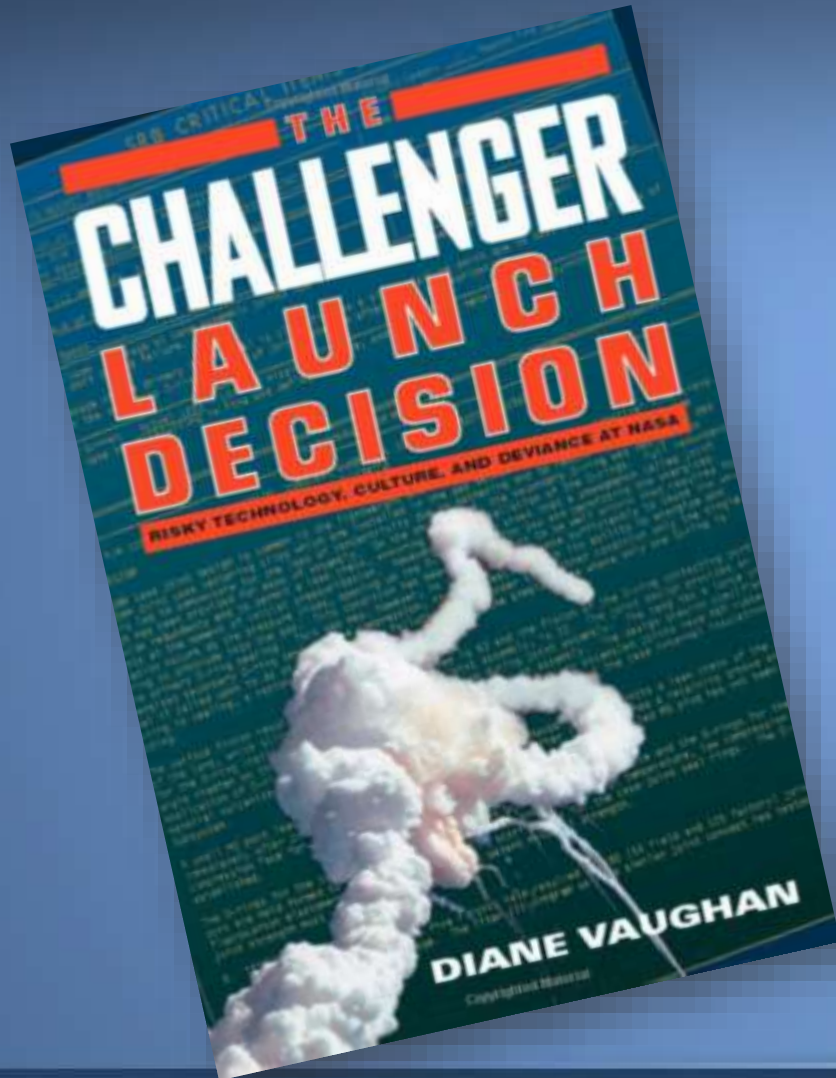


“Good can be Bad”

- With good safety performance, people/organizations can easily become complacent.
- Don't ever believe that a lack of accidents means you are “safe.”
- To counter this complacency, there must be a leadership obsession with continuous improvement.

- Courtesy of Jim Schultz

Avoid “Normalization of Deviance”



- Normalization of Deviance: When not following procedures and taking “short cuts” and becomes an accepted practice.

Avoid Selective Compliance



- “That is a stupid rule.”
- “I don’t have to comply with that one.”





Crash sharp painful memories of 1994 tragedy

By **NICOLE SWEENEY**
and **JEFF STENSLAND**
Staff Writers

It's been nearly a decade since USAir Flight 1016 plummeted from stormy skies in Charlotte, but the pain is still fresh for Wayne Mattox of Winnsboro, whose brother was one of 37 to die in the crash.

Steve Mattox and his bride, Rita, vowed to spend the rest of their lives together that day, not knowing their lives would end just hours later.

News of Wednesday's airplane crash in Charlotte brought back a torrent of memories for the Mattox family and others.

"I still think about it all the time, it's been a lot of years," Wayne Mattox said. "We could be visiting our family and we'll



FILE PHOTOGRAPH/THE STATE



NTSB



